

Bureau Talk

Missouri Department of Health
Bureau of Home Care and Rehabilitative Standards
Volume 00-4 – December 2000



Wishing everyone a
*“Joyous Christmas Season and Happy
and Prosperous New Year”*

from the staff of the Bureau of Home Care and Rehab Standards



Family Care Safety Registry

The Family Care Safety Registry, administered by the department of Health, is busy processing registration forms submitted by child-care and elder-care workers.

In December, elder-care providers were sent an informational letter describing how the registry works along with a supply of registration forms.

For those elder-care providers who did not receive the letter, the registry process is outlined below.

How does the registry work?

The Family Care Safety Registry provides background information for employment purposes only on registered child-care and elder-care workers and licensure information on licensed providers through:

- ❖ State criminal background records maintained by the Missouri State Highway Patrol
- ❖ Child abuse/neglect records maintained by the Division of Family Services
- ❖ The Employee Disqualification List maintained by the Division of Aging
- ❖ Child-care facility licensing records maintained by the Department of Health
- ❖ Foster parent, residential care facility and child placing agency licensing records maintained by the Division of Family Services
- ❖ Residential living facility and nursing home licensing records maintained by the Division of Aging

Which elder-care worker (employee) on or after January 1, 2001 is required to make

application for registration within 15 days of the beginning of employment.

Any person not required to register may also voluntarily apply to the registry if they meet the necessary requirements.

An elder-care worker who fails to submit a completed registration form as required is guilty of a class misdemeanor.

How does an employee register?

An employee may register by submitting a completed Child-Care or Elder-Care Work Registration Form, photocopy of his or her social security card and a \$5.00 registration fee to:

Missouri Department of Health
Fee Receipts Unit
P.O. Box 570
Jefferson City, MO 65102

Can an employer submit registration forms for employees?

Employers may use an Employer Transmittal and Inquiry Form to submit registration forms for employees to the registry. If this form is used, both the employee and the employer will receive results of the background check.

Instead of calling the registry, an employer may also use this form to request background information on current or prospective employee(s) who have previously registered.

How can an elder-care provider (employer) use the registry?

An employer may request background information from the registry to help ensure that only persons with appropriate backgrounds work in their elder-care facility.

An employer may call the registry's toll free telephone number 866/422-6872 to request background information on an employee or prospective employee who is registered with the Family Care Safety Registry. The employer will be required to provide their facility name and address, and the name, social security number and, if possible, date of birth of the person in question.

What background information will be released to the employer?

Upon receiving an inquiry from an employer, the registry staff will first verify that the person in question is listed in the Family Care Safety Registry. The employer will then be told whether that person's name is listed in any of the background checks and, if so, which one(s).

Specific information will only be given out after the department has received a signed request listing the employer's name and address and the reason for requesting the information.

An elder-care worker will be notified by mail each time the registry receives a request for information on his/her background. The notification will list the name and address of the person making the inquiry and the information released.

Where can an employer obtain forms or get additional information?

Missouri Department of Health
Family Care Safety Registry
P.O. Box 570
Jefferson City, MO 65102
Telephone: 573/526-1974
www.health.state.mo.us/FCSR

Toll-Free Access Line 866/422-6872



Conditions of Participation

For home health agencies which include OASIS tags are included in this mailing!



The following questions and answers are directly from HCFA's website:

Question 1:

What if a patient is referred to a HHA that is not able to either provide or arrange for a needed service?

Answer 1:

If the agency is not able to provide this service, the HHA should advise the patient on admission of the extent of its current services. The options are: 1) the agency should not accept the patient if it cannot meet all the needs; 2) the patient should be advised that the agency does not provide the service and the patient can elect to go to another HHA that provides all the needed services; or 3) the patient can decline the service and receive only the service the HHA can provide. The physician must be notified if the patient refuses a service.

Question 2:

What is an agency that does not provide therapy services to do if a patient, who on admission did not need therapy services, now develops the need for therapy during the PPS episode?

Answer 2:

The patient can elect to transfer to another HHA that can provide the services or the patient can decline the therapy service and receive only the other ordered HHA services. Again, the physician must be notified if the patient refuses the ordered therapy service.

Question 3:

NAHC published an article stating HCFA had clarified the "to" and "through" dates and HCFA would be redefining the "to" date on the 485. Is this for sure and when?

Answer 3:

Yes. Program Memorandum A-0071 effective October 2, 2000 changes the definition of the "to" date to mean "up to and including the last day of the episode which is not the first day of the subsequent episode. You may access this program memo at:

www.hcfa.gov/pubforms/transmit/A0071.pdf.

Question 4:

Can a HHA discharge a client who is in the hospital beyond the 60-day certification period? What information do we use to complete the discharge OASIS?

Answer 4:

The HHA should discharge the patient who remains in the hospital beyond the 60th day of an episode. If the transfer OASIS was completed on admission to the hospital, no further assessments are needed.

Please frequently check the OASIS and PPS home pages for current updates and more questions and answers.

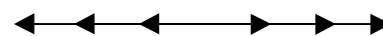
Home page PPS: www.hcfa.gov/medicare/hhmain.htm

OASIS home page: www.hcfa.gov/medicaid/oasis/oasishmp.htm

Use of the Advance Beneficiary Notices (ABN)

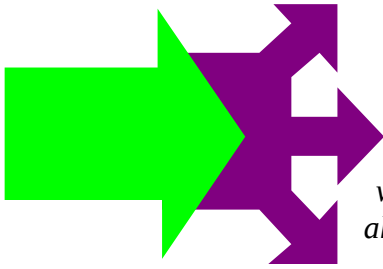
Clarification to existing requirement regarding providing proper ABNs to beneficiaries. You must give a Medicare beneficiary a proper ABN before reducing or terminating home health care the beneficiary already is receiving, if the physician's order for such care would still continue the care, and you believe that the services do not meet Medicare coverage criteria. Instances where care has not yet been initiated and you believe services ordered by the physician do not meet Medicare coverage criteria, you must provide a proper ABN. The transition to PPS does not change your responsibility. Currently, you may use model HHA ABNs designed by HCFA or forms of your own design to meet the beneficiary notification requirement. ■

SPECIAL NOTE



A Medicare provider cannot receive orders and bill for the resultant services from a Medicare sanctioned physician. Provider have HCFA resources to check any physician that is new to them or to check all their physicians. The OIG web site is the place to check:

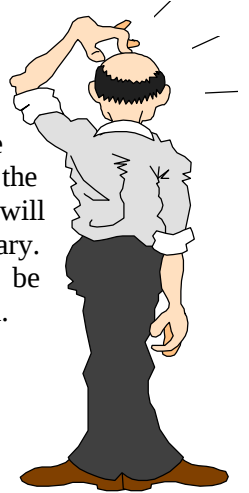
www.oig.hhs.gov/cumsan/index.htm



Home Health and Hospice Information

There have been so many changes relating to Medicare home health agencies, we at the Bureau feels overwhelmed as most of you do – well, almost as overwhelmed!

Both the Home Health Advisory Council and the Hospice Advisory Council have worked very, very hard this past year. The Home Health Council has completely rewritten the current statute for home health to include many types of home care. The Hospice Council has completed the revision of the hospice regulations. The hospice regulations were approved by the Board of Health in December and will be published for comment in the Missouri Register sometime in the near future – January or February. Please watch for that publication. The home care bill is currently in a holding pattern and will be introduced sometime during this legislative session. There are two legislators willing to sponsor the bill.



It is my understanding from the Missouri Hospice and Palliative Care Association that Congress approved a 5% rate increase for hospices. The rate increase will become effective April 1., 2001.

Problems noted regarding home health & hospice license renewal process:

1. The application forms are not always correctly completed. On the form under “name of agency,” the name of the agency is operating under must be printed here – if that is a d/b/a name then the d/b/a is the name that needs to appear in this blank. There is another area on the form for the “corporate” name. If there is a d/b/a name and a corporate name, both must be filed with the Secretary of State’s office and be in good-standing prior to our Bureau issuing a license. The Bureau cannot license an entity not in good-standing in Missouri.
2. Some licensure applications and fees are not received in our office prior to expiration of the current license. As with last year, a deficiency will be written upon expiration of the license. There will be no “grace period” since all renewal notices are mailed 60 days prior to expiration and the expiration date appears on the face of the license.
3. In some instances, agencies are not providing the Bureau with original paperwork. We must have original documents, not faxes or photocopies. We realize corporate offices are not always located in Missouri and this is sometimes difficult for the agency; however this is a requirement and must be followed. Noncompliance will result in a deficiency.

~~~~~ Information for OPT’s Only ~~~~~

There have been many questions and much discussion regarding the social and vocational service screening requirement for OPT’s. The following information is directly from HCFA: As long as the patient’s record is clearly documented to indicate the patient does not require social/vocational adjustment services, HCFA would not require a “face to face” evaluation with the patient by the OPT; **however** the documentation **must be** per a physician, qualified psychologist, social worker, etc. who **has** evaluated the patient “face to face.”